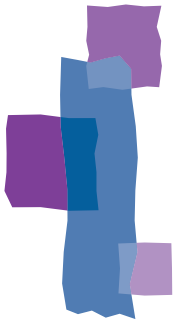


EVIDENCE-BASED PRACTICES KIT

Knowledge Informing Transformation

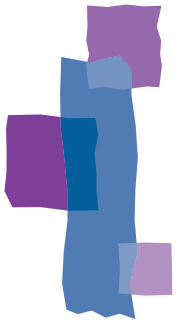
Building

Your Program

Supported Education

A Promising Practice

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
www.samhsa.gov



EVIDENCE-BASED PRACTICES KIT

Knowledge Informing Transformation

Building

Your Program

Supported Education

A Promising Practice

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administration
Center for Mental Health Services

Acknowledgments

This document was prepared for the Substance Abuse and Mental Health Services Administration (SAMHSA) by Karen V. Unger, Ph.D., Rehabilitation Through Education, Portland, Oregon, under contract number P233200500802P and Westat under contract number 270-03-6005 with SAMHSA, U.S. Department of Health and Human Services (HHS). Marian Scheinholtz served as the SAMHSA Government Project Officer.

Disclaimer

The views, opinions, and content of this publication are those of the authors and contributors and do not necessarily reflect the views, opinions, or policies of the Center for Mental Health Services (CMHS), SAMHSA, or HHS.

Electronic Access and Copies of Publication

This publication may be downloaded or ordered at http://store.samhsa.gov. Or, please call SAMHSA at **1-877-SAMHSA-7** (1-877-726-4727) (English and Español).

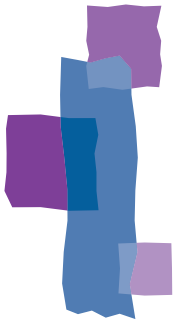
Recommended Citation

Substance Abuse and Mental Health Services Administration. *Supported Education: Building Your Program*. HHS Pub. No. SMA-11-4654, Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services, 2011.

Originating Office

Center for Mental Health Services
Substance Abuse and Mental Health Services Administration
1 Choke Cherry Road
Rockville, MD 20857

HHS Publication No. SMA-11-4654
Printed 2011



EVIDENCE-BASED PRACTICES

KIT

Knowledge Informing Transformation

Supported Education

A Promising Practice

Building Your Program

Building Your Program is intended to help mental health authorities, agency administrators, and program leaders think through and develop Supported Education. The first part of this booklet gives you background information about the Supported Education model. Specific information about your role in implementing and sustaining Supported Education follows.

Although you will work closely together to build your program, for ease, we separated tips into two sections:

- Tips for Mental Health Authorities; and
- Tips for Agency Administrators and Program Leaders.

In preparing this information, we could think of no one better to advise you than people who have worked successfully with Supported Education. Therefore, we based the information in this booklet on the experience of veteran program leaders, administrators, and consumers and end the booklet with their words of advice.

For references, see the booklet, *The Evidence*.

This KIT is part of a series created by the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services.

This booklet is part of the Supported Education KIT that includes a CD-ROM and seven booklets:

How to Use the KITs

Getting Started with Evidence-Based and Promising Practices

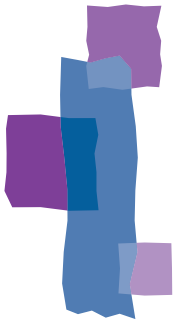
Building Your Program

Training Frontline Staff

Evaluating Your Program

The Evidence

Using Multimedia to Introduce Your Promising Practice



EVIDENCE-BASED PRACTICES KIT

Knowledge Informing Transformation

What's in *Building Your Program*

Supported Education

A Promising Practice

EVIDENCE-BASED PRACTICES

KIT

Knowledge Informing Transformation

Building Your Program

What Is Supported Education?

The onset of mental illness most commonly occurs between the ages of 15 and 21 (Newman et al., 1996) when young people are beginning to develop their adult roles. During this time, they are completing their education that prepares them to work, developing relationships that create a social network, and learning their rights and responsibilities within their communities. The onset of a mental illness disrupts this process. Once disrupted, it is extraordinarily difficult to recreate.

Supported Education programs help consumers pursue their individual educational goals. Offered in tandem with Supported Employment, these programs help consumers develop a sense of self-efficacy and independence.

Supported Education encourages consumers to think about and plan for their future. It provides an important step to help consumers use their innate talents and abilities and pursue their personal recovery goals. Also, Supported Education promotes career development to improve long-term work opportunities.

Supported Education follows the "choose-get-keep" model, which helps consumers make choices about paths for education and training, get appropriate education and training opportunities, and keep their student status until they achieve their goals (Mowbray, Brown, & Szilvagyi, 2002; Mowbray et al., 2005; Sullivan, Nicolellis, Danley, & MacDonald-Wilson, 1993).

There are several different models of Supported Education. Most offer these core services (Brown, 2002):

- **Career planning** including vocational assessment, career exploration, *Educational Goal Plan* development, course selection, instruction, support, and counseling;
- **Academic survival skills** including information about college and training programs, disability rights and resources, tutoring and mentoring services, time and stress management, and social supports;
- **Direct assistance** including help with enrollment, financial aid, education debt, and contingency funds; and
- **Outreach** including contact with campus resources, mental health treatment team members, and other agencies such as vocational rehabilitation.

Supported Education programs offer a combination of these services tailored to meet consumers' individual needs. Although often thought of as pertaining to university, community college, and postsecondary education, adult education and General Educational Development (GED) preparation can also be part of Supported Education services, thus providing a wide range of educational options to the most consumers.

The Supported Education model is based on a core set of practice principles. These principles form the foundation of the approach.

Practice Principles of Supported Education

- Access to an education program with positive, forward progress is the goal.
- Eligibility is based on personal choice.
- Supported Education services begin soon after consumers express interest.
- Supported Education is integrated with treatment.
- Individualized educational services are offered for as long as they are needed.
- Consumer preferences guide services.
- Supported Education is strengths-based and promotes growth and hope.
- Recovery is an ongoing process facilitated by meaningful roles.

Principle 1: Access to an educational program with positive, forward progress is the goal.

Consumers who want to return to school should have the opportunity to do so. Supported Education gives consumers the support necessary to fully and successfully participate in educational opportunities including adult basic education, remedial education, GED, technical programs, college, and graduate school. The goal is not just to keep consumers busy but to facilitate long-term recovery goals.

Principle 2: Eligibility is based on personal choice.

Consumers are eligible for Supported Education services if they express a desire to return to school. Psychiatric diagnosis, symptoms, cognitive impairment, history of drug or alcohol abuse, or other problems should not keep them from pursuing an educational goal. No one should be excluded from receiving Supported Education services if they are interested in resuming their education, are willing to attend class, and will complete the assigned work.

Principle 3: Supported Education services begin soon after consumers express interest.

Returning to school is a big step for many consumers. It may take courage and insight to consider returning to an environment that may hold difficult memories. It is important to respond as quickly as possible to build on the initial expressed interest. A timely response coupled with support and encouragement helps consumers return to this promising and productive role.

Principle 4: Supported Education is integrated with treatment.

Closely coordinating Supported Education services with other mental health rehabilitation and clinical treatment ensures that all mental health practitioners (not just education specialists) support consumers' educational goals. For this reason, the education specialist is part of the treatment team and an education goal is part of the treatment plan that is recorded and monitored with other goals. Although the education specialist provides Supported Education services, all members of the team help consumers meet their educational goal through an integrated service delivery process.

Principle 5: Individualized educational services are offered for as long as they are needed.

Some consumers struggle with psychiatric symptoms that persist over time so their optimal treatment and recovery requires a long-term commitment. Therefore, Supported Education services should be provided to consumers without time limits. Each academic period, individual needs of active participants are reassessed and Supported Education services are tailored accordingly. The goal is to help consumers become as independent as possible, while remaining available to provide assistance and support when needed.

Principle 6: Consumer preferences guide services.

Consumers are most motivated and work hardest when they strive to get something they want, rather than working for what others want for them. For this reason, consumer preferences guide all phases of Supported Education services. Consumers decide what they want to do and how they want educational specialists to help them.

Note: Serious mental illnesses can cause consumers to feel demoralized or discouraged. Some may need help to rediscover and express their interests and goals.

Principle 7: Supported Education is strengths-based and promotes growth and hope.

Supported Education concentrates on building for the future, rather than dwelling on the past. It is more concerned about who consumers are now and what they can accomplish, than what is holding them back. Although a realistic assessment is important so accommodations can be made, Supported Education emphasizes existing strengths that consumers can use to promote new life and career goals. Inherent in this principle is the idea that growth will occur and hope is realistic.

Principle 8: Recovery is an ongoing process facilitated by meaningful roles.

Although treatment is critical for most consumers to recover, it is not enough. The field of mental health has sometimes overlooked the importance of having meaningful roles. We are all defined by the roles we play, and consumers are no exception. Being a worker, student, family member, or friend are all meaningful roles that give context for living a meaningful life.

When consumers return to school, they assume a very valuable role in our society, that of student. This role implies forward movement, accomplishment, status, and possibilities. Returning to school is often an antidote to internalized stigma and feelings of hopelessness. It signifies a new beginning filled with promise.

As consumers return to school, others receive the message that mental illness is not an end, but like many ongoing illnesses or disabilities, involves redefining a valued person.

How do we know that Supported Education is effective?

The evidence base for Supported Education is building. Studies show that Supported Education programs lead to the following outcomes:

- **More access to and participation in educational programs** (Unger, Pardee, & Shafer, 2000; Mowbray, Collins, & Bybee, 1999; Lieberman, Goldberg, & Jed, 1993; Hoffman & Mastrianni, 1993; Cook & Solomon, 1993; Wolf & DiPietro, 1992; Dougherty, Hastie, Bernard, Broadhurst, & Marcus, 1992; Unger, Anthony, Sciarappa, & Rogers, 1991);
- **Increased competitive employment** (Unger et al., 1991; Dougherty et al, 1992; Unger et al., 2000);
- **Improved self-esteem** (Unger et al., 1991; Cook & Solomon, 1993; Mowbray et al., 1999);
- **Reduced hospitalization** (Unger et al., 1991; Isenwater et al., 2002); and
- **Increased consumer satisfaction** (Cook & Solomon, 1993; Collins, Bybee & Mowbray, 1998).

For more information, see *The Evidence* in this KIT.

Who benefits most from Supported Education?

The Supported Education model targets consumers with serious mental illnesses. The current evidence suggests that diagnosis does not affect consumers' ability to reach their education goal. Specifically, two studies show that psychiatric diagnosis was unrelated to productivity or educational attainment (Unger, Pardee, & Schafer, 2000; Smith-Osborne, 2005).

Where should Supported Education be provided?

Supported Education programs have been offered in mental health centers and educational institutions. While these were originally considered separate implementation models, recent literature suggests that most programs offer flexible services tailored to consumers' needs in different locations (Mowbray et al., 2005).

EVIDENCE-BASED PRACTICES KIT

Knowledge Informing Transformation

Building Your Program

Tips for Mental Health Authorities

Successfully implementing evidence-based and promising practices requires the leadership and involvement of mental health authorities. This section discusses why you should be involved in implementing Supported Education and the types of activities that mental health authorities typically undertake.

Why should you be interested in Supported Education?

Education is essential to obtaining satisfying work and achieving economic independence. Many consumers who have tried to return to education programs on their own have met frustration and failure because they faced stigma or lacked the necessary support.

Research studies report impressive increases in employment (from 12.9 to 64.5 percent) for consumers who participate in Supported Employment, a promising practice that helps people with mental illness find and keep meaningful jobs in the community (Bailey, Ricketts, Becker, Xie, & Drake, 1998). However, work placements are typically in entry-level and unskilled positions, and long-term employment is problematic. Forty-one to 77 percent of consumers end their employment within 6 months (Bond, Drake, Mueser, & Becker, 1997).

Given these outcomes, the challenge for education specialists is to help consumers create long- and short-term goals and access appropriate education and training opportunities to pursue their goals (Baron & Salzer, 2000; Bond et al., 2001).

Supported Education encourages consumers to think and dream about their future. It promotes career development to increase work opportunities that provide satisfaction and financial security. Supported Education is an important step to help consumers use their innate talents and abilities and achieve their personal recovery goals.

The value of education is so key. We must embrace learning as the path to true empowerment and effective personal and systems change.

— Paolo del Vecchio, 2001, p. 9.

Aren't we already offering this?

When Supported Education was being developed as a practice, some programs folded elements of Supported Education into Case Management or Supported Employment programs. To date, it seems that Supported Education programs that show the best outcomes are those with a separate organizational structure and staff focusing strictly on education.

While many similarities exist in the practice among the three programs, important differences exist as well. The table below shows the similarities and differences among the three programs.

Comparing Case Management, Supported Employment, and Supported Education

	Case Management	Supported Employment	Supported Education
Similarities	All consumers are eligible.	All consumers are eligible.	All consumers are eligible.
	Staff must have interviewing skills, goals setting, advocacy, compassion, hope.	Staff must have interviewing skills, goals setting, advocacy, compassion, hope.	Staff must have interviewing skills, goals setting, advocacy, compassion, hope.
	Staff partners with consumers to help them achieve their goals.	Staff partners with consumers to help them achieve their goals.	Staff partners with consumers to help them achieve their goals.
Differences	Staff coordinates, manages, and accounts for services.	Staff provides employment services.	Staff provides education services.
	Staff must have broad social service background, coordination, advocacy and linking skills, knowledge of community resources.	Staff must know world of work, job development, job coaching, employment accommodations, Supplemental Security Income (SSI), Social Security Disability Insurance (SSDI).	Staff must know education system, financial aid, personal support, academic accommodations.

What can mental health authorities do?

Implementing Supported Education must be a consolidated effort by mental health authorities, agency staff, consumers, and families. However, for this initiative to be successful, mental health authorities must lead and be involved in developing Supported Education programs in local communities.

Be involved in implementing Supported Education

Step 1 Create a vision by clearly articulating Supported Education principles and goals. Designate a staff person to oversee your Supported Education initiative.

Step 2 Form advisory groups to build support, plan, and provide feedback for your Supported Education initiative.

Step 3 Establish program standards that support implementation. Make adherence to those standards part of licensing criteria.

Step 4 Develop a training structure tailored to the needs of different stakeholders.

Step 5 Monitor Supported Education fidelity and outcomes to maintain and sustain program effectiveness.

Step 6 Develop funding mechanisms to support implementation.

Create a vision

Agencies commonly set out to implement one program, but end up with something entirely different. Sometimes these variations are intentional, but often they occur for the following reasons:

- One administration starts an initiative and another with a different vision and different priorities subsequently assumes leadership;
- The model wasn't clearly understood to begin with; or
- The staff drifted back to doing things in a way that was more familiar and comfortable.

Some misconceptions about Supported Education exist. One misconception is that people with mental illnesses cannot learn or cannot be successful in school. Articulating the vision that consumers can learn and earn academic degrees is essential to successfully implementing Supported Education. You can dispel these misconceptions by informing stakeholders that Supported Education services are linked to positive consumer outcomes.

To ensure that your vision is clearly articulated, designate a staff person who has experience with the Supported Education model to oversee your initiative. Some mental health authorities designate an office or staff with whom agencies may consult throughout the process of building and sustaining their evidence-based and promising practices programs. Designated staff may also have oversight responsibility for implementing Supported Education across the state.

Form advisory groups

You can ensure that the Supported Education model is implemented appropriately if you mandate that stakeholder advisory groups guide the implementation initiative. Your Supported Education initiative can benefit in many ways from an advisory group. Among other things, an advisory group can help you do the following:

- Build internal and external support;
- Increase program visibility; and
- Obtain input and feedback that contribute to ongoing planning efforts.

Consider forming local and state-level advisory groups. State-level advisory groups may include the following members:

- Representatives from consumer and family advocacy organizations;
- Representatives from the mental health authority;
- Representatives from other state agencies that would be invested in the initiative such as the Department of Education, state educational agencies, Vocational Rehabilitation, Employment, Substance Abuse; and
- Leadership from implementing agencies.

Local advisory groups can serve as liaisons between the community and agencies that implement Supported Education. Community stakeholders who have an interest in the success of Supported Education include the following:

- Representatives from local consumer and family organizations;
- Agency administrators and the program leader;
- Education specialists (staff providing Supported Education services);
- Local representatives of educational agencies, Dean of Student Affairs, the Office of Services for Students with Disabilities, the Counseling Center; and
- Other local providers such as representatives from Vocational Rehabilitation and Employment.

Facilitating your advisory group

From the beginning, you must lead your advisory groups in understanding and articulating what Supported Education is and how it is going to be developed in your mental health system. For training materials that you can use to help stakeholders develop a basic understanding of evidence-based and promising practices, see *Using Multimedia to Introduce Your Promising Practice* in this KIT.

Your mental health system may already have components of Supported Education in place. Use the tools in *Evaluating Your Program* in this KIT to assess which components of Supported Education are already in place in your mental health system and within each implementing agency.

Use your state and local advisory committees as working groups to help develop your Supported Education implementation plan based on the results of your readiness assessment. The process can involve the committee working as a whole or you could break into smaller work groups that will report to the committee.

Advisory groups should continue to meet well after you have established Supported Education. Based on experience in implementing evidence-based practices, we suggest that they meet about once a month for the first year, once every 2 months for the second year, and quarterly for the third year.

By the second and third years, advisory groups may help agencies evaluate programs by assisting with fidelity assessments and outcomes monitoring or translating evaluation data into steps for continuous quality improvement. For more information on the role of advisory groups, see *Getting Started with Evidence-Based and Promising Practices* in this KIT.

Planning your Supported Education initiative

With a vision firmly in place, the process of unfolding Supported Education across the service system can begin. Carefully planning this process will help ensure a successful outcome.

Implementing Supported Education first in pilot or demonstration sites may be useful. Working with pilot sites can help you manage problems as they arise and add to the evidence base for Supported Education.

Multiple pilot sites are preferable to just one. When only one site is used, idiosyncrasies can occur that misrepresent the model. In contrast, when mental health authorities roll the program out systemwide, training all Supported Education staff members presents a challenge. In that case, problems that may have been resolved easily on a smaller scale with a few Supported Education sites can cause havoc. This is especially true considering the evolving nature of promising practices.

Establish program standards

As a mental health authority, you have the capacity to ensure that the system has incentives to implement Supported Education in a standardized manner. Attention to aligning these incentives in a positive way (such as attaching financial incentives to achieving improved outcomes) is vital to successfully implementing Supported Education.

States have the authority to adopt regulations that govern services to consumers. These regulations set standards for the quality and adequacy of programs, including criteria that govern these areas:

- Engagement and referral;
- Assessment and treatment planning;
- Staffing;
- Program organization and service components;
- Consumer records;
- Consumer rights; and
- Supervision and program evaluation.

Support implementing Supported Education by explicitly referencing Supported Education in licensing standards and other program review documents (for example, grant applications, contracts, requests for proposals, and so forth).

You should also review current administrative rules and regulations to identify any barriers to implementing Supported Education. Work closely with agency administrators to ensure that mental health authority policies support the implementation of Supported Education.

Develop a training structure

Agencies that implement evidence-based (and similarly promising practice) models are often stymied in their efforts because people misunderstand the model or lack information. It is important that key stakeholders (consumers, families, and other essential community members) and agencywide staff develop a basic understanding of Supported Education.

We encourage you to support agency administrators in their efforts to develop a training structure for implementing Supported Education. The training plan should include the following:

- Basic training for key stakeholders including:
  - Advisory group members;
  - Staff at all levels across the agency;
  - Consumers and families; and
  - Staff from key community organizations;
- Intensive training for staff designated to provide Supported Education services.

For more information, see *Training Frontline Staff* in this KIT.

Choose your trainer

An intensive training plan for Supported Education staff may be designed in several different ways, but you must first decide who will conduct the training. Program leaders may develop the initial training for Supported Education staff by using the guidelines in *Training Frontline Staff* in this KIT. Some mental health authorities choose to hire external trainers.

One successful strategy in training Supported Education staff entails having new staff visit an existing, well-functioning, high-fidelity Supported Education program to observe how the program works. New staff will benefit most from this visit if they have a basic understanding of the Supported Education model.

Once trained, program leaders and staff will be able to use the tools in *Using Multimedia to Introduce Your Promising Practice* in this KIT to provide basic training to key stakeholders.

Offer ongoing training and consultation

Throughout the first year, we encourage you to offer Supported Education staff intermittent booster training sessions. Routine onsite and telephone consultation is also important, particularly for program leaders. Supervising Supported Education staff requires a complex set of administrative and clinical skills. For example, program leaders provide direct services and supervision, which may require a shift in thinking about consumers' potential and about how colleagues work together.

Program leaders also may have administrative responsibilities such as hiring, preparing administrative reports, and developing policies and procedures. Some programs have found that strengthening program leaders' supervisory skills through training and technical assistance is key to improving staff competencies in evidence-based practices.

It is very difficult for any staff member to grasp everything that has to be learned in a brief time. Also, understanding what must be done and translating that understanding into action are different and equally difficult. Strong daily leadership and ongoing training and technical assistance are essential to ensure that the Supported Education model is faithfully carried out.

For at least the first year a new program is in operation, staff need someone who is experienced in Supported Education to provide ongoing consultation on organizational and clinical issues. Consultation ranges from integrating Supported Education principles into the agency's policies and procedures to consulting on cases. A consultant can provide modeling and coaching either in person or with telephone support to guide you and your staff.

Followup training provided by expert consultants can also help you to meet the challenges of the new leadership roles. The specific nature of the trainings should be tailored to training needs identified through fidelity assessments (See *Evaluating Your Program* for more information).

Some states develop Supported Education in a few sites at a time so that the first Supported Education site can help train those who are in newly developed programs. Generally, it takes about a year for staff to feel confident in using an evidence-based or promising practices approach, but this can vary depending on how much structural change is needed. Agencies that are not already team-oriented or staff who are reluctant to accept new models can take longer to change.

It may take 2 to 3 years for an agency to become sufficiently proficient in the Supported Education model to assume the added responsibility of training other agencies' staff. Agencies that have become training sites indicate that involving their staff in training staff from new programs reinforces their knowledge of the model.

Other states have established training centers or enhanced existing education and training centers that offer education, training, and ongoing consultation or supervision. A state- or countywide coordinator who is experienced with the Supported Education model can also help new Supported Education sites through ongoing contact, assessment, and troubleshooting.

Monitor fidelity and outcomes

Providing Supported Education involves incorporating a new approach into the service delivery system. The best way to protect your investment is to make certain that agencies actually provide Supported Education in a way that positively affects the lives of consumers.

Agencies that adhere more closely to evidence-based models are more effective than those that do not follow the model. Adhering to the model is called fidelity.

While Supported Education is not yet an evidence-based practice, the Supported Education Fidelity Scale outlines the key elements of this promising practice. It allows agencies to implement the model in a standardized way and further evaluate its effectiveness. To do so, it is important to monitor both fidelity and outcomes.

As a central part of the initial planning process, you must address how you will monitor fidelity and outcomes for Supported Education. Too many excellent initiatives had positive beginnings and enthusiastic support but floundered at the end of a year because people did not plan how they would maintain Supported Education. Monitoring Supported Education fidelity and outcomes on an ongoing basis is a good way to ensure that the model is fully implemented. For more information about monitoring fidelity and outcomes, see *Evaluating Your Program* in this KIT.

Consider developing routine supervision and evaluations for sites that are implementing Supported Education. If that is impossible, use strategies (for example, rules, contracts, financial incentives) to support fidelity and outcomes monitoring on the local level or within individual agencies.

The characteristics of an agency that would have a perfect score on the Supported Education Fidelity Scale are shown on the next page. For more information, see *Evaluating Your Program* in this KIT.

Characteristics of an agency that would have a perfect score on the Supported Education Fidelity Scale	
Program Philosophy	The Supported Education Fidelity Scale outlines five tasks that agencies undertake to demonstrate a commitment to the program.
Supported Education Team or Specialist	The Supported Education team or specialist is designated to provide Supported Education services.
Program Eligibility	Eligibility is based solely on consumers' desire to participate in the program and on individual educational goals.
Program Preferences	Supported Education services are based on participant preferences.
Educational Assessment	Education specialists complete an educational assessment after referral to the program, which is updated each academic period.
Educational Goal Plan	An Educational Goal Plan, as specified in the Supported Education Fidelity Scale, is completed following the assessment and updated every academic period.
Congruency with Treatment Plan	The goals, objectives, and strategies of the Educational Goal Plan are congruent with the master treatment plan.
Confidence and Knowledge-Building Activities	Confidence and knowledge-building activities, as specified in the Supported Education Fidelity Scale, are available for consumers enrolled in Supported Education.
Individualized Enrollment Supports	Individualized enrollment supports, as specified in the Supported Education Fidelity Scale, are available for consumers enrolled in Supported Education.
Supports and Resources	Individualized educational supports, as specified in the Supported Education Fidelity Scale, are available for consumers enrolled in Supported Education.
Educational Progress	Supported Education staff strongly encourages consumers to achieve positive, forward educational progress.
Communication and Collaboration	Supported Education staff collaborates and communicates with clinical staff, campus personnel, and other relevant service providers as needed/requested.

Develop funding mechanisms

Each state is different. In many cases, while your Supported Education initiative can be mounted with little or no additional appropriations, it is important to review funding streams to ensure that they support your initiative.

When considering potential financial support for Supported Education, mental health authorities must decide which funding sources to develop. Potential sources include Medicaid or other outside funds, such as block grants, or money from other State or local agencies like vocational rehabilitation or substance abuse. A decision will also answer the question of how much money will come from local programs.

How is Supported Education funded?

Funding mechanisms vary from state to state.

- In one state, block grant money was used for pilot projects, with the idea of securing other funds for expansion.
- In another state, Supported Education programs were funded by the state as a standard service.
- In another state, Supported Education was a billable service blended into an overall rate as part of Supported Employment services.

Other funding options include redesigning programs to concentrate on Supported Education rather than on day treatment or other programs currently existing at the agencies. Some agencies have developed collaborative relationships with the community colleges in their area and shared staff and office space.

Several states have used Medicaid to fund Supported Employment in ways that Supported Education could be incorporated. For example, one state offered employment-related services that included developing skills to reduce or overcome the symptoms of mental illness, planning and managing activities to achieve outcomes, and developing supportive contacts in school. Another state provided employment-related services such as supportive counseling and problem-focused interventions in whatever setting was required to enable consumers to manage the symptoms of their illness.

For other innovative Medicaid funding initiatives for Supported Employment which may also be considered for Supported Education see *Using Medicaid to Support Working Age Adults with Serious Mental Illnesses in the Community: A Handbook*, published by the Assistant Secretary of Planning and Evaluation, January 2005. Go to **http://aspe.hhs.gov/daltcp/reports/handbook.pdf**

While these examples of using Medicaid are not directly related to Supported Education, they are examples of how you may define service provision to support the Medicaid mission. To ensure consistent financial support for implementing Supported Education, mental health and system administrators can work with their Medicaid counterpart to establish durable financial constructs.

EVIDENCE-BASED PRACTICES KIT

Knowledge Informing Transformation

Building Your Program

Tips for Agency Administrators and Program Leaders

Successfully implementing Supported Education requires a broad range of activities and collaboration between mental health authorities and agencies. This section assumes that the mental health authorities have initiated efforts to implement Supported Education. It outlines the types of activities in which agency administrators and program leaders are often involved.

Recruit your staff

Supported Education programs consist of a program leader and one or more education specialists, depending on the number of consumers that the agency plans to serve. While the Supported Education Fidelity Scale indicates that at a minimum staff should have some portion of their time dedicated to providing Supported Education services, others believe that education specialist positions should be full-time positions. Since education specialists juggle a variety of tasks and must be dedicated to the work, part-time positions generally do not work out well.

Education specialists should be willing to work during nontraditional work hours and in community settings. Ideally, an education specialist will be available when and where they are needed. Although being available 24 hours a day, 7 days a week is unnecessary, new students frequently need support and assistance during nontraditional work hours. This may be particularly true for consumers who study in the evening.

Having some staff working on call in the evening or on weekends will increase the sense of support some consumers may need. Include a specific amount of time that education specialists should dedicate solely to providing Supported Education services in your policies and procedures.

Choose a program leader

It is important to hire or designate a leader for your Supported Education program. We suggest that program leaders be full-time employees whose time is completely dedicated to Supported Education.

Program leaders are often mid-level managers who have the authority to make or suggest administrative changes within the agency. Successful program leaders have both administrative and clinical skills.

As part of their administrative responsibilities, program leaders undertake the following tasks:

- Hire and train education specialists;
- Develop Supported Education policies and procedures;
- Act as a liaison with other agency coordinators;
- Manage referrals to the program;
- Monitor the program's fidelity to the Supported Education model; and
- Oversee various other quality control and financial responsibilities.

As part of their clinical responsibilities, program leaders undertake the following:

- Provide Supported Education services;
- Provide weekly group supervision;
- Provide individual supervision as needed; and
- Give program feedback to education specialists.

Since program leaders must have an active role in setting up the structures and processes needed to support the Supported Education program, we encourage you to make the KIT available to candidates during the hiring process so that they will understand what they must do.

Select qualified staff

The most important characteristic of a good education specialist is the belief that people with serious mental illnesses who are interested in going back to school can complete their education and achieve their recovery goals. Education specialists must be able to encourage and inspire consumers.

Success as an education specialist appears to have less to do with academic credentials and more to do with personal style and philosophy. Positive, high-energy, and enthusiastic people who have a "can do" attitude tend to do well.

As you can see from the sample job description that follows, the education specialist's tasks are as varied as the skills needed to complete them. Desired qualifications are as follows:

- Knowledge of serious mental illnesses (including treatment, medications, and the impact of mental illnesses on learning);
- Working knowledge of a broad range of educational institutions;
- Ability to help consumers identify interests, educational goals, strengths, and challenges;
- Ability to identify and arrange short- and long-term supports to help consumers with their educational process;
- Ability to advocate effectively for consumers internally with treatment team members and externally with staff in educational institutions; and
- Ability to interface with staff in educational institutions including the Office of Services for Students with Disabilities, the Counseling Center, the Financial Aid office, faculty, and other administrative staff.

Education specialists must have strong interpersonal skills to represent the Supported Education program and network with staff in educational institutions. Other skills that will facilitate their work in supporting consumers include motivational, engagement, and counseling techniques.

Education specialists must also enjoy working in the community. A large amount of their time is spent providing support where it is needed. For this reason, education specialists should enjoy working outside of an office setting, networking, and doing whatever it takes to help consumers achieve their educational and recovery goals.

Education specialists should be able to work independently and as team members. Education specialists will not only work together as a team but will also partner with treatment team members to ensure that consumers' treatment plans reflect their educational goals.

People who become good education specialists do not necessarily come to the job with all the above qualifications. Some people can acquire knowledge and skills on the job as long as they are eager and willing to learn. Training and good supervision—along with the lessons learned through day-to-day experience—help most education specialists develop the skills and confidence to do a good job.

Job description for an education specialist	
Qualifications	The full-time position of education specialist requires a person with a bachelor's degree or above with a minimum of 3 years' experience working with people with mental illnesses. Knowledge of both the mental health system and the education system is necessary. Excellent motivational interviewing and interpersonal skills are needed to work with consumers, treatment team members, staff in education institutions, and members of the Advisory Committee. The position requires time working outside of the office and some evening hours. The ideal candidate would provide hope and inspiration to consumers and be committed to education as a road to recovery.
Job Duties	■ Help consumers with registration, financial aid, and other education institution requirements as needed ■ Establish education goals with consumers ■ Assess strengths and resources needed to meet education goals ■ Develop implementation plans for consumers including support and accommodation requirements ■ Monitor consumer progress and modify plans as needed ■ Provide support and assistance to consumers ■ Advocate and negotiate for consumers in both education and mental health settings ■ Organize peer support groups ■ Participate in treatment team meetings ■ Participate in program and staff performance evaluations ■ Participate in Supported Education training ■ Help develop and revise Supported Education policies and procedures
Supervision	The education specialist reports to the Supported Education Program Leader or its equivalent
Salary and Benefits	Comparable to other staff positions requiring similar qualifications and job duties

Build support for your program

Developing successful Supported Education services depends on the support and collaboration of a number of stakeholders. Internally, it is important that your director and staff across the agency understand the Supported Education model and support it. Your agency is more likely to successfully implement the model if your agency director is informed and involved from the start.

It is important that your agency director take the lead in promoting the Supported Education program and addressing any misconceptions. Articulate internal and public support for Supported Education by telling key stakeholders that people with mental illnesses can learn and earn academic degrees and that Supported Education services are linked to positive consumer outcomes. Emphasize the importance of your Supported Education services by demonstrating how education helps consumers get on with life beyond illness to achieve their personal recovery goals.

Once your agency director has articulated a clear vision for implementing Supported Education, continue to bolster internal support for Supported Education by providing basic information to all agency staff. For more information, see *Develop a training plan* later in this booklet.

Form advisory committees

Forming a local advisory committee is an effective way to gain key stakeholders' support for Supported Education. Identify community stakeholders who have an interest in the success of Supported Education to serve on your committee. Committees often include the following people:

- Agency administrators and the program leader;
- Education specialists;
- Representatives from consumer and family organizations;
- Local representatives of educational agencies, the Dean of Student Affairs, the Office for Services for Students with Disabilities, the Counseling Center; and
- Other local providers such as representatives from vocational rehabilitation and employment programs.

Advisory committees are most effective when the members are those people within their organizations who can make decisions and effect change. Through carefully planned and executed meetings, members' time will be well used. Their participation and expertise can help develop a Supported Education program that meets consumer needs, as well as reflects the resources of the community.

To start, your mental health authority representative or agency director should voice support for the initiative. Next, provide basic training to help advisory group members understand the Supported Education model.

To fully utilize the committee, develop an action plan that defines each member's role in implementing or supporting the new program. Timelines and deliverables also promote accountability.

Once established, advisory groups may help implement Supported Education in a variety of ways. An active and powerful advisory committee can create a vibrant program, build cooperation among agencies, and tighten the support network for the consumer. For more information, see *Getting Started with Evidence-Based and Promising Practices* in this KIT.

Sustain support

Building support for Supported Education should be an ongoing effort. Find ways to recognize and reward the achievements of Supported Education staff and consumers. For example, the Supported Education Fidelity Scale suggests sharing education outcomes internally and with community stakeholders three times a year. Organize meetings with key stakeholders in which consumers share success stories and administrators highlight staff achievements.

Another option is to sponsor a banquet to celebrate the program's accomplishments with consumers, family members, and agency staff members. Banquets are particularly helpful if a wide array of stakeholders (such as physicians, administrators, and key public officials) attend.

Your agency director and program leader should meet regularly to review program evaluation data, discuss roadblocks, and plan ways to improve your Supported Education initiative. Include consumers in every step of your evaluation and planning process.

Form collaborative relationships

It is important to establish relationships with educational institutions to dispel myths, understand and shape policies, and share resources. A common misconception is that people with mental illnesses will be disruptive on campus. Research has shown that this is not true. Studies show that consumers are not more disruptive on college campuses than other students (Parten, 1993).

Furthermore, studies suggest that the level of accommodations and services for students with mental illnesses is comparable to that of other students with disabilities. Specifically, a study task force found that students with mental illnesses who requested educational accommodations were, in fact, qualified to receive the services; they seldom requested services that were considered inappropriate (Parten, 1993).

Communicate the message that students with mental illnesses are subject to the same rights and responsibilities as all students, including abiding by Student Codes of Conduct. Understanding the guidelines and practices of each other's systems will close the gaps that have formed barriers. Collaborations will help create new ways of working together to provide more effective services for consumers.

In summary, building support from internal staff and key community stakeholders for your Supported Education initiative is essential to effectively implementing this promising practice.

Agency directors can lead this effort

- Articulate clear support for Supported Education to internal staff and key community stakeholders.
- Attend some Supported Education trainings, supervision, and advisory group meetings.
- Meet monthly with the program leader to address roadblocks.
- Facilitate ongoing planning and program improvement efforts.
- Partner with mental health authority representatives and key stakeholders.

Develop effective policies and procedures

Starting a new Supported Education initiative means developing policies and procedures that support the activities of the Supported Education model.

What policies and procedures should cover

- Engagement and referral
- Assessment and treatment planning
- Staffing
- Program organization and service components
- Consumer record
- Consumers' rights
- Program and staff performance evaluation

Outline engagement and referral procedures

When you develop your engagement and referral procedures, integrate the Supported Education principles and recommendations from the Supported Education Fidelity Scale. For example, the Supported Education Fidelity Scale suggests displaying marketing materials in multiple, highly visible locations that consumers frequent and setting up a process that encourages at least a minimum number of referrals from each treatment team.

Services should be accessible to as many consumers as possible. Consumers should not be excluded from services due to substance use, symptoms, or other readiness criteria. According to the Supported Education model, all consumers who want to return to school are eligible—no one is excluded.

Develop a simple referral process using minimal eligibility criteria. Typically, program leaders receive all referrals, review them, and pair consumers with education specialists.

Once you have developed your referral process, integrate it into your intake procedures so that consumers who are new to your agency know that Supported Education services are available. Supported Education staff and intake specialists should review how to explain the program to consumers in a way that helps them make informed decisions about accepting services.

Generating referrals takes some planning and effort at first. All of the activities designed to build support for your program (described in this booklet) can also help you generate referrals. Acquaint a variety of stakeholders with your referral process including these individuals:

- All staff in your agency;
- Advisory committee members; and
- Consumers in your agency.

The key to generating referrals is to get the word out. Elicit ideas from your advisory group and staff for engaging consumers and increasing referrals. On the next page is an example of a referral form, printed with permission from the developers at the University of Kansas, School of Social Welfare, Center for Mental Health Research and Training, which you may use as a basis for creating your own.

Supported Education Referral Form

Today's date _____/_____/_____

Name _____

Address _____

_____

Telephone (_____)_____ – _____ E-mail _____

Best methods to reach you _____

What is the highest level of school you have completed?

❑ General Educational Development (GED)	Year _____	Place _____	Completed? _____
High school	Year _____	Place _____	Completed? _____
Vocational school	Year _____	Place _____	Completed? _____
College degree	Year _____	Place _____	Completed? _____
Associate's degree	Year _____	Place _____	Completed? _____
Bachelor's degree	Year _____	Place _____	Completed? _____
Master's degree	Year _____	Place _____	Completed? _____
Ph.D. or doctoral degree	Year _____	Place _____	Completed? _____

❑ Other: Please explain _____

_____

What educational goals do you have at this time? _____

What was your favorite subject in school? _____

Which subjects did you struggle with? _____

What types of services or supports do you think you would need to succeed in returning to or continuing in school?

_____

Other information you would like to share _____

Do you access mental health or other community support services? ❑ Yes ❑ No

Program name _____ Case manager _____

Therapist _____ Referred by _____

Develop assessment and treatment planning criteria

Outline procedures for assessment and treatment planning in your Supported Education policies and procedures. In general, Supported Education staff use three tools to assess and track consumers' goals and progress:

- *Interest Inventory*;
- *Educational Assessment*; and
- *Educational Goal Plan*.

The Supported Education Fidelity Scale suggests completing these forms within 3 months after consumers are referred to the program. Information collected through these tools help education specialists work on consumer-centered educational goals.

On the next several pages are examples of an *Interest Inventory*, *Educational Assessment*, and *Educational Goal Plan*, printed with permission from the developers at the University of Kansas, School of Social Welfare, Center for Mental Health Research and Training, which you may use as a basis for creating your own.

Interest Inventory

Name _____

Today's date _____/_____/_____

Please check the following areas that you do or have interest in learning more about:

A	Candle making	**F**
Accounting	Candy making	First aid
Acting	Career planning	Flexibility conditioning
Acupressure	Career/life planning	Floral entrepreneurship
Aerobic kickboxing	Cell and molecular biology	Flowerbed design
Aerobics	Ceramics	Fly fishing
Air conditioning	Chemistry	Fossils
Algebra	Chemistry in society	French
Anatomy	Children's literature	Fused glass
Anthropology	Chinese	**G**
Appalachian clogging	Circuit training	Garment design
Apparel construction	Civil engineer	GED
Archaeology	Clay	Gemstones
Architecture	Color design	Geology
Art	Comedy	Glass painting
Art history	Computer introduction	Golf
Astronomy	Computer spreadsheets	Guitar
Automotive tech	Computer graphics	**H**
B	Concrete	Health career exploration
Ballroom dance	Construction methods	Health screening
Barn dancing	Consumer as providers	Heating
Basket weaving	Cooking	History
Basketball	Country western dancing	Hockey
Beading	Country swing dance	Holiday crafts
Beekeeping	CPR	Home economics
Bicycle maintenance	Creative writing	Home maintenance
Biology	Crime prevention	Homeownership
Botany	Criminal justice	Homeopathy
Bowling	**D**	Horses
Bread making	Databases	Horticulture
Breathing exercises	Dental hygiene	Hospitality
Breathing	Dentistry	Houseplant care
Bridge	Dental materials	Human relations
Bronze casting	Desktop publishing	Humanities
Business communications	Diesel fundamentals	Human services
Business management	Digital electronics	**I**
Business	Dollmaking	Investing
Business applications	Downhill skiing	Italian
Business law	Drafting	**J**
Butterfly gardening	Drawing	Japanese
Buying a car	**E**	Job search skills
Buying a computer	E-bay	Journalism
C	Electronics	**K**
Cake decorating	Electrical engineering	Karate
Calligraphy	Electrician	Kendo

Keyboarding	Pet safety	Social skills
L	Philosophy	Songwriting
Landscape painting	Photography	Spanish
Learning strategies	Photoshop	Special education
Leisure for lifetime	Physical education	Speech and debate
M	Physics	Spelling
Machine knitting	Piano	Spirituality and painting
Macintosh-computer	Poetry	Swimming
Magic	Programming	Swing dance
Marketing	Proofreading	**T**
Massage	Psychology	Time management
Mat class	Public speaking	Two-step dance
Math	Publishing	**V**
Medical	Puppetry	Voice
Medical transcription	**Q**	Volleyball
Meditation	Quilting	**W**
Metal and silver	**R**	Water color
Metal fabrication	Racquetball	Water exercise
Mind/body fitness	Radiology	Watercolor
Mini gardens	Railroad operations	Web design
Modern dance	Reading	Welding
Money management	Recipe modification	Wellness technology
Motorcycle maintenance	Reflexology	Windows
Music	Russian	Word processing
Mythology	Relationship classes	Writing
N	Religion	Writing strategies
Native America	Respiratory therapy	**X**
Nursing	Ring making	X-ray technician
Nutrition counseling	Rock climbing	**Y**
O	Rowing	Youth and child care
Ocean/marine	Rubber stamping	Yoga
Oil painting	Running	**Z**
Oil exploration	**S**	Zoology
Organic chemistry	Salsa dance	**Other**
Organic farming	Savings and investing	
P	Sculpture	
Paralegal	Self-defense	
Parenting	Self-healing classes	
Pastel drawing	Sign language	
Periodontics	Small engines	
Personal computers.	Soapmaking	
Personal finance	Sociology	
Personal training exercise	Soccer	

My top five picks are:

1. _____

2. _____

3. _____

4. _____

5. _____

Interest Inventory

Name _____

Today's date _____/_____/_____

Present Situation

What are the main reasons you enrolled in the Supported Education program?

- ❑ Career or educational exploration
- ❑ Help with applying for financial aid
- ❑ Help with enrolling in school
- ❑ Help with requesting academic accommodations
- ❑ Help with study skills
- ❑ Help with test-taking strategies
- ❑ Help through tutoring
- ❑ Improve math skills
- ❑ Improve writing skills
- ❑ Interest in attending preparatory classes
- ❑ Gain familiarity with college environment
- ❑ Other. Please list:_____

_____

_____

_____

_____

_____

Educational History

What is the highest level of school you have completed?

- ❑ General Educational Development (GED)
  Year _____ Place _____ Completed? _____
- ❑ High school.
  Year _____ Place _____ Completed? _____
- ❑ Vocational school.
  Year _____ Place _____ Completed? _____
- ❑ College degree.
  Year _____ Place _____ Completed? _____
- ❑ Associate's degree.
  Year _____ Place _____ Completed? _____
- ❑ Bachelor's degree.
  Year _____ Place _____ Completed? _____
- ❑ Master's degree.
  Year _____ Place _____ Completed? _____
- ❑ Ph.D. or doctoral degree.
  Year _____ Place _____ Completed? _____
- ❑ Other: Please explain

_____

_____

_____

Assessing Educational Strengths and Interests

1. What are you good at? What do you feel passionate about?
2. Using the Interest Inventory, review and rank your top three interests that you want to gain additional information about:

   1. _____
   2. _____
   3. _____

3. Do the Interest Inventory priorities that you listed match your passion or what you are good at?

   ❑ Yes. Why? _____

   ❑ No. Why not? _____

4. Thinking about the top three priorities you have selected, what educational strengths have you used in the past around the priorities listed? (For example, *I successfully completed 6 hours in History at Colby Community College. I used to take pottery classes at the Parks and Recreation Department. I participated in a book discussion group at the bookstore.*)
5. Do you have an educational goal?

   ❑ Yes. What is it? (For example, *I want to go back to school and finish my associate's degree; my dream is to become a paramedic; I'd like to learn how to use a computer; I love music and learning to play the guitar.)*

   _____

   _____

   ❑ No

6. How did you become interested in this education or career?
7. Do you have any experience in this area?

   ❑ Yes

   ❑ No

8. Do you know what the education requirements are for this goal?

   ❑ Yes

   ❑ No

9. Are you currently enrolled in school?

   ❑ Yes. What? _____

   Where? _____

   ❑ No. How soon would you like to begin classes?

   _____

10. Do you need more information about this education or training program?

    ❑ Yes. Explain. _____

    _____

    ❑ No

11. What kind of resources will you need to go forward in reaching your educational goals? (For example, *transportation, support from my family, computer access, tutor or mentor, help in filling out college application forms, tuition, books and supplies, etc.*)

    _____

    _____

12. Read and complete the Barriers to Education Checksheet.

13. What types of challenges or barriers have you faced in the past or do you think may happen in the future as you return to school? (For example, *I had a hard time talking to instructors. My medication makes me tired. I don't know how to use the computer. I had a hard time getting along with some other students. I feel uncomfortable because of my age*.) What barriers do you want to address as priorities?

_____

_____

_____

14. List some ideas that might help you overcome barriers to being in school.

_____

_____

_____

15. What has helped you in the past?

_____

_____

16. What might help you in the future?

_____

_____

17. What time of the day do you feel best?

_____

_____

18. What do you typically do during this time of day?

_____

_____

19. Who can support your desire to continue your education? (For example, *my friend, Julian; Melanie and Scott at the CRO; my case manager Alice; Don from church might tutor me; my cousin Pablo always wants to help me out*.)

_____

_____

20. Would you be interested in developing a recovery plan specifically focused for Supported Education?

- ❑ Yes
- ❑ No

21. How will you mark your progress along the way as you move toward your educational goals? (For example, *I will track my grade point average. I can ask for instructor feedback every month. I will talk to my Supported Education coach to brainstorm and problem-solve, etc.*)

_____

_____

_____

22. How will you celebrate when you reach your short-term action steps toward your long-term educational goal? (For example, *Every Saturday morning, I will meet Pam for coffee and conversation at Java Perks to celebrate that I have successfully attended all my classes for the week. After I finish my mid-terms, I will call Julian to go to the movies with me.*)

_____

_____

_____

Current Resources and Needed Resources

23. Have you applied for financial aid?

- ❑ Yes. What type? _____
  How much? _____
- ❑ No

24. Have you defaulted on a student loan before?

- ❑ Yes
- ❑ No

25. Do you owe money on a student loan?

- ❑ Yes. How much? _____
- ❑ No

26. Are you receiving funding from other sources?

- ❑ Yes
- ❑ No

27. What is your current work situation?

Full time or part-time? _____

Employer _____

Salary _____

28. Do you plan to work while continuing your education or training?

- ❑ Yes
- ❑ No

29. What supports do you currently have in the following areas?

- ❑ Community: _____
- ❑ Family: _____
- ❑ Friends: _____
- ❑ Housing: _____
- ❑ Transportation: _____
- ❑ Child care: _____
- ❑ Hobbies/recreation: _____

30. What supports will you need?

- ❑ Community: _____
- ❑ Family: _____
- ❑ Friends: _____
- ❑ Housing: _____
- ❑ Transportation: _____
- ❑ Child care: _____
- ❑ Hobbies/recreation: _____

Barriers to Education Checksheet

The following list includes common themes that serve as barriers for individuals to return or sustain their educational involvement. Use this checklist as a starting point to assess and strategize options for overcoming educational barriers.

Check the barriers that apply to you.

- ❑ Transportation. (For example, I don't have a car, and don't know how to take a bus.)
- ❑ Past failures and negative education experiences. (For example, I don't do well taking tests.)
- ❑ Side effects from medication. (For example, my meds make it hard to concentrate in class.)
- ❑ Symptoms. (For example, depression gets in the way of doing anything.)
- ❑ Academic learning skills. (For example, I'm not up to date on computers skills that I know I need for classes.)
- ❑ Fears of the unknown. (For example, when I was in college before, I didn't have a disability; what if I get sick?)
- ❑ Lack of support. (For example, I don't understand the college catalog and course requirements; I need help.)
- ❑ Funding. (For example, I need a work-study option; I don't have money to go to school.)
- ❑ Low self-esteem. (For example, I'm used to hearing how sick I am and wonder what I can really do.)
- ❑ Need accommodations. (For example, regular classes go too fast. I need someone in class who will help me out, keep me up to date and up to speed with what's going on.)
- ❑ Stigma. (For example, no one in school is as old as I am. What if someone finds out I'm a consumer?)
- ❑ Physical disability. (For example, I have a brain injury and am wheelchair-bound; it's hard to keep up.)
- ❑ Other commitments. (For example, I am in Alcoholics Anonymous (AA) right now and that takes a lot of time.)
- ❑ Don't want to commit time because of unknown results. (For example, I might have a crisis and have to go to the hospital; what if I can't finish a degree.)

Rank your top five barriers. Next to each item, write ways that you think you could overcome the barrier.

Barriers	Strategies That Might Help
1._____	_____
2._____	_____
3._____	_____
4._____	_____
5._____	_____
6._____	_____
7._____	_____

Educational Goal Plan

My overall goal for going back to school is: _____

_____

In the next 3 months my educational goal is: _____

_____

#	Short-Term Action Steps	Whose Responsibility?	Date to Do This Step	Comments	Date Step Completed
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					

Name _____ Date _____

Supported Education Specialist_____ Date _____

If your mental health authority has not already adapted these forms, we strongly encourage you to do so and incorporate them into your routine paperwork. For printable copies of the forms, see the CD-ROM for this KIT.

Establish staffing criteria

Your Supported Education policies and procedures should specify the staffing criteria for your program. In the first year, make sure your staff-to-consumer ratio is small enough to ensure that all education specialists learn how to provide high-fidelity Supported Education services. No matter how well a team is organized or how competent education specialists may be, the team will be unable to provide effective Supported Education if its caseload is too large during the first year.

Create useful job descriptions

Include clear and useful job descriptions within the staffing criteria of your Supported Education policies. For job applicants, a good position description clarifies whether a particular position matches their skills and expectations. Develop task-specific position descriptions, outline the main task categories, and detail specific duties.

Clear job descriptions allow program leaders to effectively supervise new employees and also allow employees to focus on the basic elements of their jobs.

Describe program organization and service components

Supported Education policies and procedures should include criteria for how the program is organized, how staff members relate to one another, and the types of services education specialists will provide. When you develop your criteria, integrate Supported Education principles and recommendations from the Supported Education Fidelity Scale.

Criteria should include procedures to ensure that Supported Education is provided through a team approach. Education specialists should communicate regularly with other members of the treatment team. Supported Education is most effective in an environment where education specialists are part of a treatment team. Closely coordinating Supported Education with other mental health treatment and rehabilitation ensures that everyone involved provides services that support consumers' recovery goals.

For recommendations on key service components to include in your policies and procedures, see the Supported Education Fidelity Scale in *Evaluating Your Program* in this KIT.

Involve family and other supporters

Supported Education policies and procedures should encourage and facilitate involving family and other supporters to help consumers increase their social support network. Instruct Supported Education staff to ask consumers to identify a family member or other supporter whom they would like to involve in the Supported Education services.

Involving family or other supporters help to do the following:

- Clarify consumer goals, preferences, and interests;
- Identify consumer strengths;
- Determine whether a potential educational program is a good match; and
- Provide ongoing support.

With consumers' permission, family or other supporters may attend Supported Education appointments, meet or talk with education specialists alone, or attend treatment team meetings.

Discuss how to maintain consumer records

In your Supported Education policies and procedures, describe how you will maintain consumers' records. You must keep records for each consumer and safeguard them against loss, tampering, and unauthorized use. The records should be consistent with requirements from your accrediting bodies, (such as The Joint Commission (TJC), formerly called Joint Commission on Accreditation of Healthcare Organizations; Centers for Medicaid and Medicare Services (CMS); and Commission on Accreditation of Rehabilitation Facilities (CARF).

If you are creating a new recordkeeping system, you will need materials to create records (for example, binders and forms) and to store them appropriately. You also need written policies and procedures for documenting and maintaining records. Educate your Supported Education staff and supervise them in completing the required documentation.

Ensure consumers' rights

In your Supported Education policies and procedures, discuss how you will ensure that consumers' rights are upheld. Supported Education staff should do the following:

- Be aware of the state and federal consumer rights requirements;
- Inform consumers of their rights in a meaningful way; and
- Help consumers exercise their rights.

Also, policies and procedures should reflect the model's recovery orientation. Traditional services were developed with a biomedical approach to mental health treatment. They focus on reducing symptoms and preventing relapse. In contrast, the Supported Education model is based on the concept of *recovery*. In the recovery framework, the expectation is that consumers can have lives in which mental illnesses are not the driving factors. Recovery means more than maintaining people with mental illnesses in the community. Recovery-oriented services encourage consumers to define and fulfill their personal goals, such as a goal to work or finish college.

Education specialists must believe in and be true to the recovery principles within the Supported Education model. Be careful not to replicate those elements of traditional services that simply emphasize containing symptoms and complying with medication.

The value of consumer choice in service delivery and the importance of consumer perceptions must be infused in how you provide Supported Education. Most practitioners have never examined their own attitudes and behaviors about consumer recovery and uncritically accept many clinical traditions without paying attention to how disempowering these practices are for consumers.

In recovery-based services, establishing a trusting relationship is critical. Base interactions with consumers on mutuality and respect. Challenge education specialists to listen to, believe in, and understand consumers' perspectives and take into account consumers' experiences.

Education specialists should also focus on consumer-defined needs and preferences and accept consumers' choices in service delivery. Providing Supported Education with a recovery orientation means that you support and empower consumers to achieve their individual goals.

How administrators and program leaders can help provide recovery-oriented services

- Clearly explain consumer rights in Supported Education policies and procedures.
- Offer training on recovery principles and consumer rights.
- Hold community forums using the multimedia tools in this KIT.
- Involve consumers in local advisory groups.

Evaluate program and staff performance

Evaluating your Supported Education program will help you provide high-quality services to consumers and ensure stakeholders of the program's effectiveness. Use the guidelines in *Evaluating Your Program* in this KIT to assess which components of Supported Education your agency has in place and develop an implementation plan. The Supported Education model also recommends developing a quality assurance committee that comprehensively reviews your program (using all items on Supported Education Fidelity Scale) every 6 months.

Quality assurance members, advisory group members, and Supported Education staff should work together to ensure that assessment information is used to improve the program. For more information including the Supported Education Fidelity Scale, see *Evaluating Your Program* in this KIT.

Also, develop procedures for how you will supervise and evaluate the performance of your Supported Education staff. To a large extent, clinical supervision is the process that will determine whether education specialists understand and consistently apply the model or whether further leadership, training, and accountability are required to meet this goal.

Program leaders who are experienced in the Supported Education model should provide monthly individual or group supervision to program staff. Clinical supervision should be consumer-centered and explicitly address Supported Education and its application to specific consumer situations.

Because program leaders dedicate some time to direct services, they will be familiar with all of the parts of providing Supported Education. Program leaders will not just review cases that education specialists present, but will also be able to actively problem-solve using Supported Education principles and techniques.

Program leaders also provide individual supervision to discuss performance and give feedback. Program leaders may schedule regular meetings with education specialists to review specific cases. They should be regularly available to consult with education specialists, as needed.

If the Supported Education staff is working with a consultant, the program leader should involve the consultant in group supervision and treatment team meetings. Many new evidence-based practice programs have found that feedback from an external consultant is a crucial component for improving staff performance and the quality of their program as a whole.

Develop a training plan

Developing Supported Education is a complex undertaking. Agencies that have successfully implemented Supported Education indicate that offering one-time training for education specialists is not enough. Instead, you should assess the knowledge level of key stakeholders (See *Evaluating Your Program* in this KIT) and develop a training plan.

What should your training plan include?

- Basic training for staff at all levels across the agency
- Basic training for key stakeholders, including consumers, families, advisory group members, mental health authorities, and members of key community organizations
- Intensive training for Supported Education staff

Since implementing Supported Education effectively depends on a collaborative approach, it is important for all practitioners to have a basic understanding of the Supported Education model. It is important that key stakeholders (consumers, families, and other essential community members) and agencywide staff develop a basic understanding of Supported Education. This training will build support for implementing Supported Education in your agency.

In addition to these internal basic training activities, consider organizing routine educational meetings for consumers, families, or other key stakeholders in the community where consumers who have received services through the Supported Education approach share their experiences. Events such as these can correct false beliefs before they impede implementing the Supported Education model.

Next, consider how you will offer intensive staff training to allow them to master the Supported Education model. We suggest offering four half-day training sessions using the materials in *Training Frontline Staff* in this KIT.

Hire an external consultant and trainer

Establishing processes for providing quality services requires great attention to detail. Consequently, during the first 1 to 2 years of implementing Supported Education, many agencies have found it helpful to work with an experienced external consultant and trainer.

Consultants and program leaders often work together over the first 2 years to ensure that Supported Education is structured appropriately. They integrate Supported Education principles into the agency's policies and tailor Supported Education procedures to meet local needs.

Once the program has been launched, it is important that you do not allow staff to revert to older and more familiar ways of doing things. External consultants and trainers who are experienced in implementing Supported Education can provide ongoing technical assistance, supervision, and periodic booster training sessions. This type of assistance, along with ongoing evaluation of fidelity and outcomes, has been found to be critical in sustaining an evidence-based approach.

Review your program budget and revenue sources

You must understand your Supported Education program budget and revenue sources so that you can actively participate in the budgeting process, make informed management decisions, understand where collateral revenue sources are most needed, and sustain the program. In some mental health systems, programs receive a fixed rate for each consumer who receives services. In other systems, programs are reimbursed only based on specific services provided. In that case, you should be familiar with how to track services to capture billing from various funding streams. You also must know the billing process and billing codes.

Financing mechanisms for Supported Education vary. Supported Education services have been funded using Medicaid, Vocational Rehabilitation funding, and other sources. For more information, see *Develop funding mechanisms* early in this booklet.

A budget for Supported Education will include the following:

- Staff salaries;
- Staff time for training; and
- Strategic planning.

Other important elements include costs for office space, technology (phones, computer, copying), materials, staff travel time and student financial needs. Travel for advisory board members including consumers and family members also must be considered.

In summary, implementing the Supported Education approach effectively is a developmental process. We encourage you to periodically revisit the information in this KIT throughout the first year after starting your Supported Education initiative. We believe that these materials will take on a new meaning as the process of implementing Supported Education evolves.

EVIDENCE-BASED PRACTICES

KIT

Knowledge Informing Transformation

Building Your Program

Voices of Experience

Those who have successfully implemented Supported Education and those who have received their services are the best people to advise you. This section provides a description of a successful Supported Education program as written by a long-time staff member. The description is followed by two success stories from consumers who have received services from the Supported Education program.

Consumers and Alliances United for Supported Education

Consumers and Alliances United for Supported Education (CAUSE) has helped people with psychiatric disabilities attend postsecondary education institutions since 1991. It is a mobile support program whose home office is located in a mental health center in Quincy, Massachusetts. Education specialists meet students most often at other sites, including area colleges and universities and three local psychosocial clubhouses.

Much of the work is done by phone. Of the five practitioners and two volunteers who work in the program, CAUSE has five consumer/providers. Paid practitioners are state employees. The program has approximately 140 participants at any given time, 100 who are enrolled in college classes.

CAUSE staff work with the students as long as those students want services. Some may need numerous contacts during the first semester, with the intensity of services declining over time to the point where they function without help. Others stay involved for as long as 6 years. The average length of stay is 3 to 4 years.

Most students attend school part-time. Students continue to be involved in the program if they "stop out," a period of time when they may not be attending classes because of the exacerbation of their illness or other life situations.

The staff-to-student ratio is approximately 1 to 30+, depending on the number of hours that a counselor works. The general rule is that if staff members work 30 hours per week, then they would have a caseload of 30 students. A staff member who works 40 hours a week would have a caseload of 40 students.

The number of hours spent with students varies, depending on their needs. Some students may check in weekly by telephone while others may prefer face-to-face visits weekly, every other week, or monthly. Duration of student encounters may last 10 minutes to more than an hour. In certain instances, an encounter with a student may exceed 3 hours if a counselor must drive a student to and from college for an appointment.

To become eligible for the program, students must have a serious mental illness and live within the service area. The breakdown of identified diagnosis for the enrolled students is:

- Bipolar disorder (26 percent);
- Schizophrenia (22 percent);
- Schizoaffective disorder (18 percent);
- Major depression (12 percent); and
- Posttraumatic stress disorder (10 percent).

To enroll, students participate in an intake appointment and complete an application. A writing sample on the application form helps staff determine the student's readiness for college enrollment. Most students have had some college (43 percent) and some have earned a baccalaureate or graduate degree (13 percent).

Students begin the educational process by discussing their career goals and interests with staff. They visit potential schools. Financial aid, registration, and documentation are completed. Meetings may be arranged with college support services staff.

If someone is not ready for college enrollment, they are encouraged to enroll in an adult education class. The adult education helps them gain school experience, assess their capabilities, and identify their need for accommodations.

Community involvement and collaboration are important components of the program's success. To support and maintain these connections, the CAUSE Executive Board meets monthly and invites representative from schools and mental health and vocational agencies. Reports may be given and information shared. Part of the meeting includes a guest speaker.

CAUSE practitioners also serve on area and statewide committees and coalitions and are participants in the Massachusetts Services for Education and Employment (SEE) Coalition that includes 25 programs statewide. The mission of the SEE Coalition is to enhance the efforts of each SEE program by collaborating, educating, and advocating to ensure that a diverse network of services are provided across the Commonwealth. They believe that education and employment are the pathways to a person's meaningful identity in society.

In 2007, the CAUSE program placed 105 students into 279 educational placements. Students successfully completed 232 courses or 83 percent of their coursework. Forty percent of those enrolled in school were also working part-time. The programs also serve a small number of transitional aged youth.

CAUSE practitioners attribute their success and longevity to three things:

- The unconditional positive regard given to students;
- Offering support to students as long as it is needed; and
- The strength of the program's community collaborations.

Living with Mental Illness—Gaston Cloutier

I came from a textbook-style dysfunctional family. My father was an alcoholic and my mother was depressive. I decided at an early age to rise above the squalor of my childhood home and become a doctor or a lawyer.

Some people believed I was a super-achiever in high school. Some thought I was an over-achiever. I think I was both. Anyway, when it was all over, I was designated an Outstanding Teenager of America, chosen for Who's Who in American High Schools and, most important, was selected to be a Cornell National Scholar.

Yes, a 4-year free ride to an Ivy League School. I had it made … but not so fast. Enter Schizoaffective Disorder. In the second semester of my freshman year, I had become mentally ill and had to leave school.

So began 15 years of unbridled insanity. To shorten a very long story: I flunked out of college, joined the Navy (a hippie in the Navy?!), went A.W.O.L., hitched to Canada, nearly starved to death in Montreal, turned myself in, spent time in the brig, swallowed some L.S.D. and ended up in the Naval Hospital Psychiatric Ward.

This hospitalization was the first in a string of approximately 10 hospitalizations over a period of 15 years. In addition to my hospital stays, among other things, I hitched cross-country, stole cars, spent a little time in jail, had several devastating romances, was court-committed to a state hospital, attempted suicide … and you ask, "Is there more?"

Amazing Grace … God gave me a second chance. It came in the shape of a one-two punch. The first was the Boston University's Center for Psychiatric Rehabilitation Supported Education Program. This revolutionary program helped me regain my self-esteem and get job skills. It guided me to my undergraduate degree.

I mentioned earlier that I started college at Cornell from 1972-1973. Twelve years later, with the support of the B.U. Program, I found myself back in school. I started out with four courses at Assumption College in Worcester, MA. I am still affiliated with the Assumptionists to this day, after having spent some time in their Formation Center in 1987.

Geographically, Framingham State College was much closer to my home, so I started going there in 1988. Unfortunately, I was still symptomatic so I "stopped out" several times. It was taking so long to get a degree that I decided to switch to a community college so that I would at least have an Associate's Degree.

I enrolled in Massachusetts Bay Community College in 1990. After six consecutive semesters, taking two courses at a time, I graduated with high honors. I went back to Framingham State College and earned my B.A. in Liberal Arts. As I mentioned earlier, this education and religious phase was the first stage of my "comeback." Secondly, 2 months after I graduated from college, I was hired by CAUSE. That was 13 years ago. I still work at the same job. I'm an educational counselor. I'm married and have a condo and two cars. We are very active in our church.

Miracles do happen!

My Road Back to College—Louise Landau

My road back to college began with a great deal of encouragement and support from my education and employment providers. In the past, I had been a student at George Washington University and then Boston University, from the fall semester of 1971 through spring semester of 1975. I failed to complete college because I was hospitalized multiple times due to my mental illness.

I became healthier through support from my day treatment providers and with a great deal of support from my local clubhouse. I had completed two transitional employment placements and was hoping for a permanent job when I met with my vocational rehabilitation counselor. He surprised me by saying, "There is no future in going from department store to department store. You can do things with words that your friends cannot do. You belong in college."

I had reservations about attending school because I had stopped reading. My counselor explained that my mental illness had affected my learning. He believed in my ability to do well in a college environment. He believed that with the right amount of tutoring and supportive environment I could be successful.

My re-entry into college began with a Bunker Hill Community College in the spring of 1990. I chose this school due to its friendly environment. I enrolled as a Liberal Arts Studies student. Unfortunately, my mental illness began to intensify. During this time, my CAUSE counselor supported me in completing the coursework. She connected me with Bunker Hill's Disability Office, which enabled me to access the accommodations and support I needed to complete my coursework.

Throughout this period, I continued to be hospitalized periodically. I re-engaged in day treatment and began regularly attending my local clubhouse to help in my recovery process. In the fall of 2003, I graduated from Bunker Hill Community College in Liberal Arts Studies with a 3.45 grade point average. One leg of my journey was completed.

CAUSE continued to support me as I climbed the educational ladder. My counselor encouraged me to apply to the University of Massachusetts, Boston, to pursue my bachelor's degree. I was quickly accepted. My counselor provided me with the guidance I needed to navigate the college system at UMASS.

In the fall 2005, I began taking three courses a semester as an English major. That same fall I began working part-time in the circulation department at the Brookline Public Library. I loved my work both in school and at the library. I graduated in June 2006 from UMASS Boston with a 3.22 average.

Since graduation, I have become committed to pursuing a career as a librarian and furthering my education by attending a master's program in graduate studies in library science. I worked diligently on my preparation for the Graduate Record Examination.

I took the GRE in February with accommodations and received a 590 on the verbal, a 480 on the quantitative skills, and 3.5 on analytical writing. I have applied and been accepted to Simmons College of Library Science.

Throughout this process I have received a great deal of support from CAUSE and my team. I continue to push through the obstacles I am faced with and work toward a more enriching future.

HHS Publication No. SMA-11-4654
Printed 2011

28858.1210.8712010402

A Life in the Community for Everyone

SAMHSA

Substance Abuse and Mental Health Services Administration

U.S. Department of Health and Human Services